CHAPTER 4
Documentation and Record Keeping

- **Lesson Purpose**

  To give the student an introduction to the necessity of documentation and detailed guidelines for proper documenting within the health care profession.

- **Lesson Objective**

  Upon completion the student will:

  - Learn the necessity for proper documentation
  - Learn common documentation methods and abbreviations
  - Learn the necessary components of the patient file
  - Understand special considerations for documentation

"You've got to be very careful if you don't know where you are going, because you might not get there."

—Yogi Berra

Introduction

As part of the legal duty owed to patients, every health care provider is ethically and legally required to record evaluative and treatment-related information about their patients and to maintain that information in the form of daily patient treatment records.

The patient record is a written or computerized record of a particular patient's health status at a given point in time. Each entry is a "snapshot" of the patient's condition, the decisions of the care provider, and the treatment rendered based on those decisions.

The daily record should include pertinent information that is clear, concise, comprehensively detailed, individualized, accurate, and timely. Some sources would go so far as to state that the documentation of a patient encounter is as important as the encounter itself.

General Disclaimer

This document contains recommendations for the clinical documentation of chiropractic care. These recommendations are intended for educational and instructional purposes only and do not constitute a standard of care for any specific clinical situation. These recommendations, which may need to be updated, are intended to be flexible.

The recommendations and directives within this text should be considered basic and not comprehensive. One must always refer to state and federal guidelines to assure legal compliance when creating and maintaining patient records. The types of recording methods and formats utilized are dynamic, and subject to change readily over time.

The recommendations herein would apply to all patients at all places where services are rendered. Documentation guidelines are consistent and universal, regardless of locale, technique, philosophy, method of reimbursement, or liability coverage status.

These guidelines are intended to provide a common framework for patient records that allows for more consistent reporting and improved communication both within and outside the provider's practice.

Necessity for Proper Documentation

Proper patient records serve many purposes. They serve as narrative descriptions of a provider's experiences with a patient at any given point in time. They serve as historical records of the patient's case progression which could be a valuable tool in many instances. They are also legal documents that may be referenced by many sources to determine necessity, validity, and effectiveness of care and critical decision-making.

- **Daily notes are a valuable communication tool for other healthcare providers or case managers who may necessitate review of the record to determine a proper supportive or collaborative course of care.**
- **The patient's treatment notes aid internal case management and concurrent planning of care.**
- **The patient's file can serve as a valuable tool in quality of care assessments.**
- **The daily record can serve as both proof and justification for those responsible for payment.**
- **Treatment notes play a valuable role with regard to litigation proceedings.**
- **Concise patient records can help to acknowledge adherence to a standard of care.**

Format

The most commonly accepted type of clinical record keeping is the SOAP format. This format records information about **S**ubjective complaints, **O**bjective findings, the doctor's **A**ssessment and treatment **P**lans and/or procedures employed in an organized manner (See Figure 5.a). Other formats and derivatives of the basic SOAP style of patient charting include the POMR (Problem-oriented Medical record), CHEDDAR (Chief complaint, History, Exam, Details, Drugs/dosages, Assessment, and Return/referral), SNOCAMP (Subjective, Nature, Objective, Counseling/consultation, Assessment, Medical decision making, and Plan), and SORE (Subjective, Objective, Rx/treatment, and Exercise/ergonomics).

A consistent and organized method of maintaining daily records (regardless of acronym) allows information to be recorded in a predictable, repetitive manner. Proprietary or "in-office" systems of documentation are ill-advised due to the difficulty of other parties to readily understand, comprehend, or decipher at critical times.

Abbreviations: Abbreviations are often necessary and quite acceptable when making patient chart entries. Care must be taken to utilize commonly-accepted abbreviations since interpretations of individualized or proprietary symbols could be erroneous. Abbreviations can save both time and space, but the use of non-standard abbreviations should always be accompanied by a clear interpretational key or glossary.

Generation of Health Records: Providers may exercise any method of recording patient information that is commonly acceptable, legible, and readily accessible. Typically, the style of recording and maintaining daily notes is a matter of preference, but other factors such as costs or other external mandates could also dictate choices.

Documentation Tips and Guidelines:

- Patient notes must be consistent, accurate, and contemporaneous
- Chart entries must be both legible and indelible
- All notes must be arranged and recorded chronologically
- Each entry must be signed or initialed by the party who performs a given service
- Chart corrections must be made via a single strike through (~~error~~; *cjh*) accompanied by the initials of the party who creates the correction and the date of the correction. (no "white-out," erasures, or mark-overs)
- Records must be easily and readily retrievable

Necessary Components of the Patient File

Demographics:

Initial patient intake information
Clear identification of the doctor and clinic (name, address, etc.)
Patient identification (name, Social Security Number [SSN] or other unique identifier)
Patient address, sex, and occupation (type and place)

Clinical:
Health history (with dates of significance)
Medications and allergies
Chief complaint, description of presenting problem(s)
HPI (history of present illness/problem)
ROS (review of systems)
Examination findings
Clinical impression(s)
Chart/progress/daily notes
Other pertinent clinical information or acquired records/reports
Any re-evaluations/re-examinations
Reports of any radiographic procedures performed
Treatment plan and updates

Miscellaneous
Necessary financial/payment records
Work/school slips
Documentation of phone calls or external conversations
Lab or Durable Medical Equipment (DME) orders
Significant evidence of non-compliance

Each patient encounter should be considered as a unique occurrence and treated as such within the record. In keeping with the concept of each note being a "snapshot," frozen in time, the record should reflect any and all necessary components that led to the patient's presentation and any care rendered or referral made. Therefore, minimal notations on successive or repeat visits should not be rationalized as acceptable simply due to the doctor's familiarity with the patient or due to a seeming redundancy of the presentation or treatment. While the detail and verbosity of successive visits may not rival that of the initial one(s), the importance of portraying each visit as a stand-alone entity should not be discounted.

SOAP Notes

S=Subjective

The subjective portion of the patient record, whether relative to the initial intake or the daily encounter documentation, remains focused on the patient's self-evaluation of symptoms and progress. Subjective information is based exclusively in the patient's opinions, perceptions, and self-expression, and is not evidence that is reproducible or based in objectivity.

Examples of subjective reporting include but are not limited to the following:

- The patient's pain scale (1-10)
- The patient's complaint(s)
- The patient's history
- Details of the patient's lifestyle and home life
- The patient's expression of emotions or attitudes
- The patient's stated goals
- The patient's reported response to treatment
- Anything the patient says or shares that is pertinent to his/her case or condition

Often times, quoting patients verbatim can be a useful and even necessary method of recording their subjective expression. Whenever quoting a patient specifically, be sure to utilize quotation marks to signify the beginning and closing of the specific quotation, and to quote accurately within the record.

In summary, the subjective can simply be defined as what the patient says, tells, or reports.

O=Objective

Objective reporting is defined quite the opposite of subjective expressions within the patient record. Objective findings are measurable, repeatable, reproducible findings that have basis in common evaluative procedures.

Examples of objective findings include but are not limited to the following:

- Passive range of motion (PROM)
- Active range of motion (AROM) with instrumentation
- Blood pressure
- Pulse rate
- Temperature
- Height
- Weight
- Deep tendon reflexes
- Comparative muscle testing
- Laboratory results
- Orthopedic tests*

**Semantically speaking, provocative orthopedic testing of the spine and extremities is not a purely objective evaluative tool. Provocative testing (by true definition) relies on the patient to report a subjective response to a given movement or maneuver, thereby disqualifying it as being reproducible, measurable, or repeatable without the patient's subjective input. Most sources will list orthopedic testing within the objective realm of the SOAP note derivation, and for the purposes of this text it will remain there as well. However, it is prudent to note the clinical weakness of orthopedic testing as a truly objective tool.*

A=Assessment

The assessment portion of the SOAP note takes into consideration the provider's opinion as to the origin of symptoms and conditions, as well as the inventory of the patient's progress (or lack thereof). Some sources go so far as to call the assessment portion "the doctor's subjective."

Some providers choose to create a running "problem list" for each patient, along with a regular revisitation and evaluation of the patient's progress for each item on the problem list.

The assessment can also simply include the patient's diagnosis, the provider's opinion as to progress, or assumptions as to why progress may be stalled or stifled.

Simply put, the assessment is the analysis of plans and goals for the patient. This may include the provider's perception of the patient's

potential for rehabilitation or recovery, suggestions for changes in the regimen of care or home treatment, or any other factors that may assist the provider or any successive caregiver to direct the patient's care more accurately.

To this point in the record, we have determined the patient's expression (S) and we have evaluated the complaint/complaints (O). With the assessment, we correlate the two: what the patient said + what we find = what we think (or S+O = A)

P = Plan/Procedure

The final portion of the SOAP note is the plan/procedure section. This section simply correlates the previous three into action. Once all information is gathered, evaluation is performed, and determination of condition or stage is made, any reaction to this conglomeration of data is recorded in the final portion of the note. We have a clear picture of what is going on with the patient; now, what are we going to do about it? (S+O=A→P)

Within this section, any rendered treatment is described and detailed, as well as the projected future frequency and duration of said treatment. If a referral is made, it is recorded here.

Other possible inclusions within the plan/procedure section:

- Recommendations for home care
- Activity/work limitations
- Prescription of supplements, supports, or braces
- Ergonomic advice
- Equipment needs
- Additional testing needs
- Short and long-term goals
- Coordination of care with other providers

Documentation Special : Medicare

The Centers for Medicare and Medicaid Services (CMS) have established specific policies for the payment of claims for chiropractic services. Specifically, CMS currently only pays for *manual manipulation of the spine to correct a subluxation*. As such, the presence of said subluxation must be properly documented in order to establish medical necessity for treatment on each visit.

Specifically, Medicare requires **three** components to be present in order to establish medical necessity:

1. A subluxation that causes a significant neuromusculoskeletal condition
2. Documentation of the presence of the subluxation
3. Documentation of the initial and subsequent visits

If documenting the presence of a subluxation via physical examination (as opposed to simply relying on the claim of the presence of a subluxation on an X-ray) Medicare requires the "**PART**" documentation system to be used.

The components of "PART" documentation are detailed below. CMS requires that two of the four components be documented each visit, and that one of those must always be either the "A" or the "R" component.

P = Pain / Tenderness

Observation:

Document, by personal observation, the pain that the patient exhibits during the course of the examination. Note the location, quality, and severity of the pain

Percussion, Palpation, or Provocation:

When examining the patient, ask him/her if pain is reproduced, such as, "Let me know if any of this causes discomfort."

Visual Analog Type Scale:

The patient is asked to grade the pain on a visual analog type scale from 0-10.

Audio Confirmation:

Like the visual analog scale, the patient is asked to verbally grade their pain from 0-10.

Pain Questionnaires:

Patient questionnaires, either standardized or "in-house," may be used for the patient to describe his/her pain.

A = Asymmetry/Misalignment

Identify on a sectional or segmental level by using one or more of the following:

Observation:
Observe patient posture or analyze gait.

Static and Dynamic Palpation:
Describe the misaligned vertebrae and symmetry.

Diagnostic Imaging:
X-ray, CAT scan and MRI may be used to identify misalignments.

R = Range of Motion Abnormality

Identify an increase or decrease in segmental mobility using one or more of the following:

Observation:
Observe an increase or decrease in the patient's range of motion.

Motion Palpation:
Record your palpation findings, including vertebrae listing(s). Record the various areas that are involved and related to the regions manipulated.

Stress Diagnostic Imaging:
X-ray the patient using bending views.

Range of Motion Measuring Devices:
Devices such as goniometers or inclinometers may be used to record specific measurements.

T=Tissue/Tone Changes

Identify using one or more of the following

Observation:
Visible changes such as signs of spasm, inflammation, swelling, rigidity, etc.

Palpation:
Palpated changes in the tissue, such as hypertonicity, hypotonicity, spasm, inflammation, edema, tautness, rigidity, flaccidity, etc. can be found on palpation.

Use of Instrumentation:
Document the instrument used and findings.

Tests for Length and Strength:

Document leg length, scoliosis contracture, and strength of muscles that relate.

While Medicare documentation requirements are very specific, it is possible to meet the requirement for documenting a subluxation within daily chart notes, if the PART format is followed as described.

Common Abbreviations

Abbreviations can be useful in enhancing the speed and brevity of daily note-taking. Many abbreviations are commonly used across healthcare disciplines, and should be used in common context regardless of provider. Some individuals may have created unique symbols, gestures, or modifications of current abbreviations for their own use. If unique symbols are utilized, it is imperative to include a definition key with the file. The list below is not an exhaustive compilation, but a compilation of commonly used abbreviations and symbols that may have utility within the chiropractic practice.

>: greater than	<: less than	: change
↓ : decreased	↑ : increased	Ø : none, no
R: right	L : left	B : bilateral
~: approximately/about	1° : primary	2° : secondary
3° : tertiary	a.: before	a.c.: before meals
ab: abdominal	AC: acromioclavicular	ad feb.: fever present
ad int.: in the interim	ad lib.: as wanted	adj.: adjustment
ADL: activities of daily living	agg: aggravate	ant.: anterior
AP: anteroposterior	AROM: active range of motion	b.i.d.: twice per day
BCP: birth control pills	BM: bowel movement	BP: blood pressure
c: with	c/o: complains of	C: cervical

CA: carcinoma	CBC: complete blood count	CBR: complete bed rest
Cerv/CS: cervical/cervical spine	CMT: chiropractic manipulative therapy	CP: cold packs
C/T: cervicothroacic	CT: computed tomography	CTD: cumulative trauma disorder
CTS: carpal tunnel syndrome	CVA: cerebrovascular accident	CVD: cardiovascular disease
D: dorsal [*syn*. Thoracic]	D/C: discontinue	DD: differential diagnosis
DDD: degenerative disc disease	DIP: distal interphalangeal joint	dimin: diminished
DJD: degenerative joint disease	DRG: dorsal root ganglion	DSLR: double straight leg raise
DTR: deep tendon reflex	Dx: diagnosis	ECG or EKG: electrocardiogram
EEG: electroencephalogram	EMG: electromyography	EMS: electrical muscle stimulation
EPP: end point pain	ES: erector spinae muscles	ESI: epidural steroid injection
ESR: erythrocyte sedimentation rate	Exac.: exacerbation	ext: extension
FH: family history	fix: fixation	flx: flexion
Fx: fracture	GH: Gleno-humeral	GI: gastrointestinal
GU: genitourinary	HA: headache	HEENT or EENT: head/eyes,ears,nose,throat
hmp: hot moist packs	HNP: herniated nucleus pulposis	HPI: history of present illness
HR: heart rate	HTN or HIT: hypertension	HV: high volt

HVG: high volt galvanism	Hx: history	ice mass: ice massage
IF or IFC: interferential current	IM: intermittent or intermuscular	imp: improved
inf.: inferior	iso: isometric	IT or IST: intersegmental traction
ITB: iliotibial band	IVD: intervertebral disc	IVF: intervertebral foramen
KJ: knee jerk	L or lum: lumbar	lat: lateral
LATX: long axis traction	LBP: lower back pain	LC: lower cervical
LD: lower dorsal	LE: lower extremity	LLF: left lateral flexion
LLI: leg length inequality	LLQ: left lower quadrant	LMN: lower motor neuron
LR or LROT: left rotation	L/S: lumbosacral	LS: lumbar spine
LUQ: left upper quadrant	LV: low volt	m: muscle; (mm.: muscles)
mass: massage	MBP: midback pain	MCP: metacarpophalangeal joint
MCRC: maximum cervical rotatory compression	med: medial	MLR: maximum lifting restriction
MP: motion palpation	MTP: midthoracic pain or metatarsalphalangeal joint	MVA: motor vehicle accident
NAD: no abnormalities detected	NBM or NPO: nothing by mouth	NCV: nerve conduction velocity
NKC: no known cause	NKI: no known injury	N/L: normal limits

nn.: nerves	nr: nerve root	OA: osteoarthritis
occ.: occipital	OTC: over the counter	p: after
p.c.: after meals	PRN: as needed	PE: physical examination
PERRLA: pupils equal, round, reactive to light and accommodation	PH: past history	PIP: proximal interphalangeal joint
PMI: point of maximum intensity	pn or px.: pain	PNF: proprioceptive neuromuscular facilitation
PPD: permanent partial disability	PROM: passive range of motion	PT: physical therapy
Pt. ed.: patient education	Pt. or pt.: patient	PT: physical therapist
q.a.m.: every morning	q.d.: every day	q.h.: every hour
q.i.d.: four times per day	q.o.d.: every other day	q.p.m.: every afternoon/evening
QL: quadratus lumborum	RA: rheumatoid arthritis	rad: radiate, radiation
RLF: right lateral flexion	RLQ: right lower quadrant	RTW: return to work
RO or R/O: rule out	ROM: range of motion	RR or RROT: right rotation
RUQ: right upper quadrant	Rx: recommended or prescription	s: without
SAC: sacral	SA: sacral apex	SB: sacral base
SC: sternoclavicular joint	SCM: sternocleidomastoidious muscle	Sho: shoulder

SI: sacroiliac joint	SLR: straight leg raise test	SMT: spinal manipulative therapy
SOB: shortness of breath	SP: spinous process	Stat.: immediately, at once
STM: soft tissue massage	Sup.: superior	SWD: short-wave diathermy
Sx, S/S: symptoms; signs and symptoms	t.i.d.: three times per day	thor: thoracic
T/L: thoracolumbar	TMJ: temporomandibular joint	TOS: thoracic outlet syndrome
TP: trigger point	TPD: temporary partial disability	TPR: temperature, pulse and respiration
TPT: trigger point therapy	trap: trapezius	TS: thoracic spine
tt: taut and tender	TTD: total temporary disability	ttt: tender to touch
tx, trxn: traction	Tx, Tmt: treatment	UA or U/A: urine analysis
UE: upper extremity	URI: upper respiratory infection	US: ultrasound
UTI: urinary tract infection	UV: ultraviolet	VSC: vertebral subluxation complex
WLR: well leg raise test	WNL: within normal limits	w/o: without
WP: whirlpool	x: number of times performed [x2 = twice; x3 =three times, etc.]	XR: X-ray
yo: years old		